

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2010
NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38586		
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F 000	INITIAL COMMENTS During complaint investigation #24504, #24464, #24323, and #23908, conducted on January 19-21, 2010, at Generallons Center of Spencer, no deficiencies were cited in relation to the complaints under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	The facility failed to update contact information on resident #10. The record of resident #10 was updated on 01/22/10 by the social worker to reflect current family contact information. Each resident identification sheet was reviewed by the social service director on 01/22/10 to ensure accurate information was placed on individual resident records. The social service director will review each resident identification sheet quarterly to ensure information is current and accurate. A sample of five identification sheets will be audited monthly by the facility secretary to ensure social service director is maintaining compliance. 10% of charts will also be reviewed quarterly for quality by the medical records nurse/ L.P.N. the results will also be reviewed quarterly by the quality assurance committee. The committee consists of: the quality assurance nurse, the director of nursing, administrator, social service director, cont. next page	01/22/10	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		
			(X6) DATE		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to update family contact information for one (#10) of fifteen residents reviewed. The findings included: Resident #10 was admitted to the facility on May 9, 2008, with diagnoses including Cerebral Palsy and Borderline Personality Disorder. Medical record review of nurse's notes revealed the licensed nurse attempted to call the resident's brother on October 29, 2009, after the resident fell, and the brother's phone number was disconnected. Continued review revealed resident #10 fell again on November 12, 2009, and no contact number was available, so the resident's brother was not notified of the fall. Interview with the Social Services Director (SSD) and Case Manager (CM) #1 on January 21, 2010, at 9:35 a.m. in the Social Services Director's office, revealed the SSD and CM #1 were unaware the resident's brother's phone had been disconnected, and confirmed updated contact information was not available until January 21, 2010, at 1:00 p.m.	F 157	cont. from previous page activities director, MDS coordinator, case managers, dietary manager, maintenance director, medical director and pharmacy consultant.	01/22/10	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	The facility failed to ensure the care plan was revised when a behavior modification program was initiated for resident #14. There was no immediate corrective action for resident #14, who was cont. next page	02/23/10	

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F 280	<p>Continued From page 2 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the care plan was revised when a behavior modification program was initiated for one (#14) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident # 14 was admitted to the facility on December 22, 2008, with diagnoses including Chronic Atrial Fibrillation, Schizoaffective Disorder, and Bipolar Disorder.</p> <p>Medical record review of nurse's notes revealed a Weekly Summary, dated July 10, 2009, "Resident allowed to use...personal cell phone if meds taken as scheduled. Resident likes to call...sister (name) on...cell phone."</p>	F 280	<p>cont. from previous page discharged on November 30, 2009</p> <p>The mental health case managers met with the MDS coordinator and director of nursing on 1/28/10 to discuss each resident on a behavior modification program. The updates were completed by the director of nursing by 02/23/10 for each individual plan of care where behavior modification program was identified. All information received on resident behavior modification programs will be discussed in the individual care plans for determination of significance in plan of care. The care plans will be updated by the MDS coordinator. A 24-hour shift summary which is the communication log was placed at the nurses station to increase communication between the nursing staff, social workers, MDS coordinator and mental health nurse practitioner. Staff was educated on use and purpose of the communication log on 02/23/10 by the director of nursing, who developed the communication log. The charge nurse will update the communication log daily. The effectiveness of the communication log will be reviewed monthly by the quality assurance committee, which consists of:</p> <p>cont. next page</p>		02/23/10

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F 280	Continued From page 3 Medical record review of the current care plan, revealed the use of the cell phone to modify the resident's behavior was not addressed on the care plan. Interview with the Social Services Director and Case Manager #1 on January 21, 2010, at 9:10 a.m., in the SSD's office, revealed the resident was allowed to use the cell phone, if...look medications as scheduled, at the request of the resident's conservator. Continued interview confirmed the use of the cell phone was utilized to encourage the resident to take medications as scheduled, and confirmed the cell phone program was not addressed on the comprehensive care plan.	F 200	cont. from previous page the quality assurance nurse, the director of nursing, administrator, social service director, activities director, dietary manager, case managers, maintenance director, medical director, MDS coordinator, and the pharmacy consultant .	02/23/10	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure physician's orders were followed for two (#14, #1) of fifteen residents reviewed. The findings included: Resident #14 was admitted to the facility on December 22, 2008, with diagnoses including Schizoaffective Disorder, Bipolar Disorder, and	F 309	The facility failed to ensure physician's orders were followed for resident #14 and #1. There was no immediate corrective action for resident #14, who was discharged on November 30, 2009. TED hose were applied to resident #1 on 01/21/10 by the wound care nurse/ L.P.N. Physician's orders were reviewed by the director and assistant director of nursing for each resident on 01/29/10, to ensure all physician's orders were followed through. If a medication or treatment is refused or not given the nurse will circle the medication or treatment on the medication/ treatment administration record and document on the back why it cont. next page	02/08/10	

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F 309	<p>Continued From page 4</p> <p>chronic Atrial Fibrillation. Medical record review revealed the resident was discharged to another facility on November 13, 2009.</p> <p>Medical record review of physician's orders revealed a telephone order, dated January 13, 2009, for Zyprexa (antipsychotic) 5 mg (milligrams) one every morning and 5 mg one at bedtime "may give IM (intramuscular) if won't take PO (orally)". Continued review of physician's orders revealed when the Zyprexa was increased to 10 mg 1 po bid (twice a day) "may give IM if refuses PO." Medical record review of physician's orders revealed the Zyprexa was discontinued on August 19, 2009.</p> <p>Medical record review of nurse's notes revealed resident #14 spit out meds as follows March 5, 2009 at 1000; March 24, 2009, at 0730; April 28, 2009, at 0830; and July 27, 2009, at 2100, "spit out meds in BR (bathroom)." Medical record review of nurse's notes and the Medication Administration Records (MARS) from March, 2009, thru July, 2009, revealed the resident did not receive Zyprex via injection, as ordered, on any of the above dates.</p> <p>Medical record review of physician's orders and MARS from March, 2009, thru July, 2009, revealed on March 1, 2009, resident #14 was receiving Zyprexa 5 mg every morning and 10 mg at bedtime (total of 15 mg). Continued review revealed on July 1, 2009, Zyprexa was increased to 10 mg twice a day (total of 20 mg). Medical record review of physician's orders and MARS for July, 2009, revealed the Zyprexa was again increased, with a 2:00 p.m., dose of 5 mg added (total of 25 mg).</p>	F 309	<p>cont. from previous page</p> <p>it was not completed. If a medication or treatment is refused twice consecutively the physician will be notified by the charge nurse. The quality assurance nurse (L.P.N.) will review the weekly wound care sheets to provide a summary of current treatments at 100% and observe 10% of wound care monthly to ensure compliance with medication/ treatment administration. The director and assistant director of nursing will monitor compliance with medications and treatment administration for one month weekly and then as needed to ensure all physician's orders are carried out. All nurses were in-serviced on 02/08/10 by the director of nursing. All nurses will be monitored annually for proper medication/ treatment administration by the director of nursing within 30 days of their annual hire date.</p>		02/08/10

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F 309	<p>Continued From page 5</p> <p>Interview with the Assistant Director of Nursing, in the conference room, on January 21, 2010, at 11:30 a.m., revealed the injection was to be given when the resident refused to take the Zyprexa or later spit the Zyprexa out. Continued interview with the ADON confirmed the physician's order was not followed four times between March 5, 2009, and July 27, 2009.</p> <p>Resident #1 was admitted to the facility on December 6, 2008, with diagnoses including Diabetes, Peripheral Vascular Disease (poor circulation in the legs), History of Toe Ulceration with Amputation, and Left Forefoot Amputation.</p> <p>Medical record review of the December 2009, physician's recapulation orders revealed "...apply black TED hose (compression stockings) before rising in the morning and remove at bedtime..."</p> <p>Medical record review of the Podiatrist's progress note dated December 11, 2009, revealed "...Treatment Plan: Will continue using the compression stockings to keep the swelling down..."</p> <p>Observation on January 20, 2010, at 8:30 a.m., and 12:40 p.m., in the resident's room, revealed the resident with white cotton socks on both feet.</p> <p>Observation and interview on January 21, 2010, at 10:40 a.m., with the Director of Nursing (DON) and the resident in the resident's room revealed the resident lying on the bed with white cotton socks on both feet. Interview with the resident revealed the staff frequently does not offer to apply the black TED hose for the resident, and the resident is unable to apply the black TED</p>	F 309		

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F 309	Continued From page 6 hose to the feet. Interview with the DON confirmed the resident's black TED hose had not been applied. Observation and interview with Licensed Practical Nurse (LPN) #6 on January 21, 2010, at 11:25 a.m., in the resident's room revealed the resident had edema in both feet. Interview with LPN #6, confirmed the physician's order was not implemented.	F 309			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide adequate supervision to prevent a fall for one (#8) of fifteen residents reviewed. The findings included: Resident #8 was admitted to the facility on December 11, 2007, with diagnoses including Dementia with Behavior Disturbance, Depressive Disorder, Mild Mental Retardation, Diabetes with Neuropathy, and Peripheral Vascular Disease. Medical record review of the Minimum Data Set (MDS) dated December 2, 2009, revealed the resident had moderately impaired cognitive skills, required extensive assistance with	F 323	The facility failed to provide adequate supervision to prevent a fall for resident #8. The care plan was updated on 01/22/10 to reflect a change in the level of supervision by the director of nursing to include the following interventions: the resident will be up in chair with body alarm and propel self in halls. The resident will be assisted to toilet following meals and assisted back to bed if he so chooses. The director of nursing reviewed each resident on the fall awareness program by 02/23/10 to ensure compliance with the plan of care. Fall assessments will be completed on admission, post significant change, post fall and quarterly by the MDS coordinator and charge nurses. The fall policy was updated by the director of nursing and the administrator on 02/01/10. All staff were educated by 02/23/10 on the updated policy. cont. next page	02/23/10	

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F 323	Continued From page 7 transfers/ambulation, and had fallen in the past thirty days. Medical record review of the Fall Risk Assessment dated October 17, 2009, and December 14, 2009, revealed the resident was at high risk for falls. Medical record review of a nursing note dated November 18, 2009, at 8:00 a.m., revealed "This res (resident) found sitting in floor at...bedside. Assessment revealed (no) injuries...Fall was unwitnessed..." Medical record review of a Fall Care Plan dated November 18, 2009, revealed "...Resident will not be left in hallway or alone in room in w/c (wheelchair). Take resident from dining room directly to...room & assist to bed." Medical record review of a nursing note dated November 22, 2009, at 1:40 p.m., revealed "Attempted to get into bed et slid into floor. (no) injuries noted..." Observation on January 20, 2010, at 8:13 a.m., revealed the resident lying on the bed. Interview on January 20, 2010, at 11:45 a.m., with the Director of Nursing, in the conference room, confirmed the resident was unattended at the time of the fall on November 22, 2009, and the Fall Care Plan was not followed.	F 323	cont. from previous page The director of nursing will assess, evaluate and implement changes to prevent the reoccurrence and promote safety and fall prevention by reviewing each incident, each assessment and trending data and interventions put into place. A weekly meeting will be held by the interdisciplinary team to review falls. The inter- disciplinary team consists of: MDS coordinator, the director of nursing, social service director, activities director, dietary manager. The weekly meetings began on 02/02/10. The quality assurance committee will review effectiveness of the fall prevention program quarterly, by trending falls, locations, times and review findings submitted by the fall committee. The quality assurance committee consists of: the quality assurance nurse, the director of nursing, the MDS coordinator, administrator, social service director, activities director, maintenance director, dietary manager, medical director case managers, and pharmacy consultant.	02/23/10	
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it	F 441	The facility failed to wash hands during a dressing change for resident #8 and #1. The director of nursing spoke with the nurse with the deficient practice on It, was determined there was a need for a more experienced cont. next page	01/22/10	

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F 441	<p>Continued From page 8</p> <p>investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the staff failed to wash the hands, during a dressing change for two (#8, #1) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Observation on January 19, 2010, at 2:01 p.m., revealed Licensed Practical Nurse (LPN) #4 providing wound care to resident #8. Observation revealed LPN #4 donned gloves and removed soiled dressings from the right and left lower legs. Observation revealed without changing the gloves or washing the hands, LPN #4 cleansed two open wounds on the right lower leg, and three wounds on the left leg, with wound cleanser and gauze pads. Continued observation revealed without changing the gloves or washing the hands, LPN #4 applied Triple Antibiotic Ointment to each of LPN #4's gloved fingers, and then used each of the five fingers to individually apply the Triple Antibiotic Ointment to the five wounds on the lower legs. Continued observation revealed without changing the gloves or washing the hands, LPN #4 applied dressings to the five wounds.</p> <p>Review of the facility's policy Skin Integrity Program revealed "...Put on gloves...Remove soiled dressing...Cleanse wound with wound</p>	F 441	<p>cont. from previous page</p> <p>nurse in the wound care position. A new wound care nurse an L.P.N. with more experience began on 01/21/10. An in-service for all staff was conducted on 01/22/10 on infection control and universal precautions. The in-service was conducted by the director of nursing and assistant administrator. All nurses will be checked off annually by the director of nursing on skill performance and medication/treatment administration compliance. The infection control/ quality assurance nurse/ L.P.N. will make unannounced rounds throughout the facility and monitor a total of nine employees, with members from each department to be included. All staff is encouraged to practice better handwashing techniques through postings in the restroom demonstrating proper handwashing and reminding all staff of when to wash hands.</p>	01/22/10			

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F 441	<p>Continued From page 8</p> <p>cleanser... Remove gloves and complete hand hygiene... Put on new gloves... Apply prescribed ointments if indicated... If you are dressing more than one site on a resident, hand hygiene must be done between each site..."</p> <p>Interview on January 20, 2010, at 11:10 a.m., with LPN #4, in the Assistant Director of Nursing's office, confirmed the gloves were not changed and the hands were not washed during the wound care provided to resident #8 on January 19, 2010, at 2:01 p.m.</p> <p>Resident #1 was admitted to the facility on December 6, 2008, with diagnoses including Diabetes, Peripheral Vascular Disease (poor circulation in the legs), History of Toe Ulceration with Amputation, and Left Forefoot Amputation.</p> <p>Observation on January 20, 2010, at 9:20 a.m., in resident #1's room, of LPN #4 provide treatment to a open wound on the resident's right fifth toe. Observation revealed: LPN #4 applied gloves; removed the resident's sock; a Certified Nurse Assistant entered the room and handed LPN #4 a tube of ointment for another resident (contaminated) and LPN #4 put the other resident's tube of ointment into the uniform pocket; without removing the contaminated gloves or sanitizing the hands LPN #4 removed the soiled dressing on the resident's foot; removed the soiled gloves and without washing or sanitizing the hands applied clean gloves; cleansed the wound with wound cleanser and dried it with gauze pads; without washing or sanitizing the hands applied Silvadene ointment with a cotton swab using the cotton end, then turned the cotton swab around and used the</p>	F 441			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 10 contaminated wooden end to smooth the ointment onto the wound; without washing or sanitizing the hands applied the dressing to the wound; reapplied the resident's sock; put soiled items including the soiled gloves into a bag; disposed of the bag in the the trash compartment on the treatment cart; and without washing or sanitizing the hands placed the wound cleanser bottle and the jar of Silvadene in the treatment cart. Interview with LPN #4 on January 20, 2010, at 9:35 a.m., in the hallway outside of resident #1's door, revealed the hands were sanitized prior to assembling the bottle of wound cleanser, gauze, jar of Silvadene, cotton swab, and the dressing, and confirmed the hands were not washed or sanitized until all items were replaced in the treatment cart.	F 441			
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to notify the physician of laboratory results for two (#8, #7) of fifteen residents reviewed. The findings included: Resident #8 was admitted to the facility on December 11, 2007, with diagnoses including history of Deep Venous Thrombosis, Mild Mental Retardation and Diabetes with Neuropathy. Medical record review of the December 2009,	F 505	The facility failed to notify the physician of lab results on resident #8 and #7. The medical director was notified of lab results on 01/21/10 by the assistant director of nursing/ L.P.N. Medical records nurse/ L.P.N. reviewed recent lab draws, results, and physician notifications on 01/25/10. The medical records nurse, L.P.N. will review lab results 3x weekly and will notify the medical director as labs are ordered and results are received. If lab services are unable to be obtained the charge nurse and/or the assistant director of nursing will notify the medical director cont. next page	01/25/10	

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NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 30585		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 505	<p>Continued From page 11</p> <p>physician's recapitulation orders revealed the resident was receiving Coumadin (anticoagulant) 4mg (milligrams) daily, and a PT/INR (laboratory test to measure blood coagulation) was to be completed every month.</p> <p>Medical record review of a PT/INR laboratory report dated December 22, 2009, revealed PT 25.1 (reference range 11.9-14.4) and INR 2.2 (reference range 2.0-3.5). Medical record review of the same PT/INR laboratory report revealed the laboratory report was faxed to the physician on December 23, 2009, however, medical record review revealed no documentation the physician had received/reviewed the laboratory report.</p> <p>Interview on January 21, 2010, at 9:35 a.m., with the Assistant Director of Nursing, in the conference room, confirmed there was no documentation the physician was notified of the results of the laboratory report.</p> <p>Resident #7 was admitted to the facility on July 10, 2008, with diagnoses including Atrial Fibrillation (abnormal beats of the heart), Hypertension, Arteriosclerotic Heart Disease, and Sick Sinus Syndrome (abnormal rhythm of the heart).</p> <p>Medical record review of the physician's recapitulation orders revealed: "...December 24, 2008, Digoxin level every 3 months ...March 24, 2009, PT/INR (measures how fast blood clots), Potassium, Liver Function every month ...August 21, 2009, BMP (Basic Metabolic Function) HEP (liver) function once a month ..."</p> <p>Medical record review of the laboratory report dated September 10, 2009, revealed "...Digoxin</p>	F 505	<p>cont. from previous page</p> <p>As orders are written for labs, the medical records nurse/ L.P.N. will review the orders daily and compares the orders to the log book to ensure compliance with completion and notification of lab results. The quality assurance committee will review 10% of charts during the monthly meeting with the inclusion of labs to ensure compliance with notification of lab results. The quality assurance committee consists of: the quality assurance nurse, the director of nursing, administrator, social service director, activities director, case managers, MDS coordinator, maintenance director, medical director, dietary manager and pharmacy consultant.</p>	01/25/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2010
NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38585		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 505	<p>Continued From page 12</p> <p>0.1 (L) (reference range 0.8-2.0 ng/mg) faxed...9/11/09 ..." Medical record review revealed no documentation the physician had received/reviewed the laboratory report.</p> <p>Medical record review of the laboratory report dated September 22, 2009, revealed Hepatic Function Panel Total Protein 5.2 (L)...(reference range 6.2-8.0 g/dl)... Globulin 1.9 (L)(reference range 2.1- 3.7 g/dl)...Prothrombin time (PT) 15.0 (H) (reference range 11.9-14.4 seconds) INR 1.2 (L) (reference range 2.0-3.5 seconds) faxed ...9/23/09 ..." Medical record review revealed no documentation the physician had received/reviewed the laboratory report.</p> <p>Medical record review of the laboratory report dated September 24, 2009, revealed " ...Digoxin 0.4 (L)(reference range 0.8-2.0 ng/mg)...faxed to M.D. 9/25 ... Medical record review revealed no documentation the physician had received/reviewed the laboratory report.</p> <p>Medical record review of the laboratory report dated October 20, 2009, revealed " ...Digoxin 0.3 (L) (reference range 0.8-2.0 ng/mg)...Prothrombin time (PT) 15.5 (H) (reference range 11.9-14.4 seconds) INR 1.2 (L) (reference range 2.0-3.5 seconds) faxed to M.D. 10-21-09 ... Medical record review revealed no documentation the physician had received/reviewed the laboratory report.</p> <p>Medical record review of the laboratory report dated December 3, 2009, revealed " ...Digoxin 0.3 (L) (reference range 0.8-2.0 ng/mg)...Prothrombin time (PT) 15.3 (H) (reference range 11.9-14.4 seconds) INR 1.2 (L) (reference range 2.0-3.5</p>	F 505			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 445300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2010
NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38585	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 505	Continued From page 13 seconds) faxed 12-14/09 ... Medical record review revealed no documentation the physician had received/reviewed the laboratory report. Medical record review of the laboratory report dated January 5, 2010, revealed " ... INR 1.0 (L) (reference range 2.0-3.5 seconds) Basic Metabolic Panel Glucose 138 (H) (reference range 73-107 mg/dl) ... Calcium 8.6 (L) ... (reference range 8.7-10.4 mg/dl) ... Hepatic Function Panel Total Protein 5.3 (L) (reference range 6.2-8.0g/dl) ... Globulin 2.0 (L) (reference range 2.1-3.7 g/dl) ... faxed to MD 1/7/10 ... Medical record review revealed no documentation the physician had received/reviewed the laboratory report. Interview on January 21, 2010, at 9:10 a.m., with the Assistant Director of Nursing in the conference room revealed the physician was notified January 21, 2010, before the interview and the physician confirmed ... was unaware of the results and ordered the resident's dosage of Coumadin to be changed from 4mg daily to 6mg daily.	F 505		
F 508 SS=D	483.75(k)(1) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview,	F 508	The facility failed to ensure radiology services were obtained as ordered for resident #4. The medical director was notified on 01/20/10 by the assistant director of nursing, a chest x-ray was completed on 01/20/10, the physician was notified of the results the same day. Each chart was reviewed by the director of nursing on 01/26/10 to ensure cont. next page	01/26/10

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NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 508	Continued From page 14 the facility failed to ensure radiology services were obtained as ordered for one (#4) of fifteen residents reviewed. The findings included: Resident #4 was admitted to the facility on October 6, 2006, with diagnoses including status post Cerebrovascular Accident and Bipolar Disorder. Medical record review of physician's progress notes revealed on November 23, 2009, a chest xray was obtained due to resident #4's complaints of congestion and wheezing. Continued review revealed the physician ordered Avelox (antibiotic) once a day for seven days, and a repeat chest xray in three weeks. Medical record review of radiology reports revealed a repeat chest xray was not obtained until January 20, 2010. Interview with the Assistant Director of Nursing on January 20, 2010, at 2:10 p.m., in the conference room, confirmed the physician's order was not followed and the chest xray was not obtained in a timely manner.	F 508	cont. from previous page there was no additional radiology services ordered. As orders are written for radiology services the medical records nurse/L.P.N. will review the orders daily and compare the orders to the log book to ensure compliance with completion and notification of radiology services. The quality assurance committee will review 10% of charts during the monthly meeting with the inclusion of radiology services to ensure compliance with notification and completion of services. The assistant director of nursing notified the physician of the results of the chest x-ray completed on 01/20/10 for resident #4. The quality assurance committee consists of: the quality assurance nurse, the director of nursing, administrator, social service director, case managers, dietary manager, MDS coordinator, maintenance director, medical records nurse, and pharmacy consultant. See next page for F 514	01/26/10	
F 514 SS=D	483.75(1)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514			

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F 514	<p>Continued From page 15</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was accurate for two (#12, #14) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #12 was admitted to the facility on August 27, 2004, with diagnoses including Schizoaffective Disorder, Psychotic Disorder, and Debility. Medical record review of a Consultant Pharmacist Communication to the Physician dated July 15, 2009, revealed "...Antipsychotic Gradual Dose Reduction (GDR) Risperdal (antipsychotic) 4mg (milligrams) qHS (every hour of sleep)...Based on a review of the MDS (Minimum Data Set), progress notes and nursing record, it was felt by this reviewer that a GDR could be attempted. Please consider the following trial dose reduction: decrease Risperdal to 3mg qHS..." Medical record review of a physician's order dated July 20, 2009, revealed the Risperdal was decreased to 3mg in the evening.</p> <p>Medical record review of the Mental Health Notes, completed by the Psychiatric Nurse Practitioner, dated August 4, 2009, September 21, 2009, November 30, 2009, and January 18, 2010, revealed the Psychiatric Nurse Practitioner documented the resident continued to receive Risperdal 4mg at hour of sleep, after the</p>	F 514	<p>The facility failed to ensure the medical records were accurate for resident #12 and #14. The medical record for resident #12 was reviewed by the mental health nurse practitioner and an updated note was placed on the chart on 01/25/10 to reflect accurate documentation of medications. There was no immediate corrective action for resident #14, who was discharged on November 30, 2009. The mental health nurse practitioner reviewed the mental health progress notes for each individual resident from 01/25/10 and 02/01/10 to ensure medications and dosages were documented properly. A communication sheet was developed by the director of nursing and the mental health nurse practitioner to maintain updates on resident medications and behavioral changes. The mental health nurse practitioner will review physician's orders prior to completing progress notes and recommendations for medication adjustments. An in-service was completed on 02/01/10 by the director of nursing. The A.D.O.N. will update the log as behaviors occur. All behavioral medication changes will have a physician's order written and a copy of the order will be posted under the mental health tab for the mental health nurse by the charge nurse. .cont next page</p>	02/01/10	

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NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38585		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 514	<p>Continued From page 16</p> <p>Risperdal was decreased to 3mg on July 20, 2009.</p> <p>Interview on January 21, 2010, at 11:20 a.m., with the Director of Nursing (DON), in the DON's office, confirmed the Mental Health Notes/medical record was not accurate.</p> <p>Resident #14 was admitted to the facility on December 22, 2008, with diagnoses including Schizoaffective Disorder and Bipolar Disorder.</p> <p>Medical record review of the Mental Health Notes, completed by the Psychiatric Nurse Practitioner, dated August 24, 2009, revealed the resident received Zyprexa (antipsychotic) 5 mg one time a day. Medical record review of physician's orders revealed Zyprexa was discontinued on August 12, 2009.</p> <p>Medical record review of the Mental Health Notes, completed by the Psychiatric Nurse Practitioner, dated July 27, 2009, revealed the resident received Zyprexa 5 mg 1 every day. Medical record review of the physician's orders revealed the resident received Zyprexa 10 mg po twice a day, and Zyprexa 5 mg once every day.</p> <p>Interview with the Director of Nursing in the Social Services Director's office on January 21, 2010, at 9:15 a.m., confirmed the Mental Health Notes were inaccurate.</p>	F 514	<p>cont. from previous page</p> <p>The mental health nurse practitioner will be monitored monthly by the psychiatrist. The quality assurance committee will monitor 10% of charts monthly with the inclusion of the mental health progress notes to ensure compliance. The quality assurance committee consists of: the quality assurance nurse, the director of nursing, administrator, MDS coordinator, medical records nurse, social service director, activities director, case managers, dietary manager, medical director, maintenance director and pharmacy consultant.</p>	02/01/10	